What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

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DO YOU SPEAK MATHEMATICS?

What is the sum of **"One** strategy, **two** goals, **six** milestones, **15** steps, and **20** activities**"?**

For nearly a decade, the Navrongo Health Research Centre (NHRC) has conducted field research, demonstration, and training directed at developing, testing, and disseminating systems for community-based health care. Initially launched as a three-village pilot in 1994, and phased in as a field experiment in 1996, the Community Health and Family Planning project (CHFP) began to demonstrate evidence of success by 1998. Informal exchanges between project investigators and visiting District Health Management Teams (DHMT) generated a series of replication projects in other districts. Beginning in 1999, the Community-based Health Planning and Services (CHPS) Initiative was derived from the need to organize a national programme, based on the experience of a few DHMT that had visited Navrongo and adapted CHFP services to local needs and conditions. Since the creation of CHPS, enthusiasm for community-based care has grown, as indicated by reports from the Ghana Health Service (GHS) Policy Planning Monitoring and Evaluation (PPME) Division showing that nearly all DHMT intend to launch the programme. However, PPME monitoring has also shown that this enthusiasm to plan CHPS implementation has not translated into successful action in many districts. Moreover, individuals responsible for coordinating implementation are often unclear about the CHPS agenda and ways to get work started. Thus, without guidance from coordinators, and without experience with actual service delivery, there is mounting confusion about how to proceed, with many districts unable to proceed beyond the planning stage. This problem can be addressed with an experience-based counterpart-training programme for CHPS implementation teams—coordinators, DHMT members members and potential Community Health Officers (CHO). Training will provide district participants with hands-on experience with CHFP operations, implementation strategies, and pilot planning. Trainees will complete the essential tasks of zoning districts, launching community entry, and establishing pilot services. Experience gained will provide CHPS with a team of knowledgeable coordinators and frontline staff with a clear sense of their mission in the programme.

Navrongo is an ideal site for orienting health staff to the challenges and charms of community-based health service operations

The CHPS Initiative. The CHPS Initiative has established a website at www.ghana-chps.org that explains the national strategy for the programme and presents monitoring results. DHMT are encouraged to launch the programme in steps and phase in operations in work areas termed "zones" where components of the programme are implemented over time. In each zone where CHPS is implemented, there are 20 implementation activities embedded in 15 steps. Steps, in turn, produce six essential milestones in implementation: planning for the process, "community entry" (orienting chiefs and leaders), constructing or renovating "community health compounds" (CHC) where nurses live, posting trained nurses to CHC, acquiring essential equipment, and launching volunteer services. Where CHPS functions well, districts have been mapped and zoned into catchment areas where the six milestones are phased in over time, according to staff capacity, resource availability, and community readiness to launch the programme.

The Problem

Though countrywide enthusiasm for CHPS has accelerated, this enthusiasm has been offset by serious obstacles. Monitoring results of the Policy Planning Monitoring and Evaluation (PPME) Division show that most districts that have stated in reports that they intend to launch the initiative remain at the "planning" stage, unable to cross over to other milestones and move forward. Only about 10 districts have so far been able to deploy a CHO to a community to provide service. Zones where CHPS is in full-scale operation comprise less than five per cent of the population of Ghana. Carefully conducted PPME qualitative appraisal of the programme has clarified some of the reasons for this "implementation gap." It is attributed to a variety of reasons including, but not limited to, fear of community health

nurses being deployed in village locations and then forgotten; suspicion among other health staff afraid that the Community Health Officer (CHO) would diminish their role and importance; community members feeling they are being shortchanged by being sent "low cost" health services when they have asked for a hospital or clinic; and inability of the DHMT to engage the various stakeholders in dialogue to get things off the ground. District leaders and supervisors share a certain fear of the unknown, particularly in regard to financial commitments, and the prevalent view that external resources are required to get CHPS started.

The Solution

Without a firm grasp of the concept of CHPS, fears in getting started, to a very large extent, are justified. Regional and District CHPS Coordinators have been appointed in all the regions and districts to address these problems and coordinate CHPS activities; yet they are not well oriented regarding CHPS and are thus poorly positioned to bridge the "implementation gap." There is the need for practical demonstration of the program that puts participants at ease with the CHPS initiative and develops consensus for CHPS implementation. Since 1997, Navrongo has hosted DHMT with this objective. Now there is a need to extend this approach to include the newly constituted cadre of CHPS Coordinators also so that they have a firm grounding in the steps and concepts underlying the programme that they are coordinating. This is based on the observation that districts where remarkable progress has been recorded are all led by DHMT members who have visited Navrongo, Nkwanta, or other districts where the program is operating and received practical training in how to launch the programme. Under counterpart systems training—designed to demonstrate all aspects of the CHFP service regimen—all health staff can receive practical orientation. In this approach, the system is demonstrated by expert participants to counterparts who observe operations and adapt lessons to their own local circumstances and needs. When Navrongo orientation has worked well, it has led to pilot implementation of the CHPS programme in one or two zones where learning-by-doing takes place, followed by counterpart demonstration in the implementing district. The Navrongo approach is therefore more a matter of starting a catalytic process than a program for technical training. This involves:

- *Orienting counterparts to key concepts*. The notions of steps, zones, community mapping, community participation, and so on, is demonstrated with the aim of providing direct experience with implementation of CHPS activities, problems encountered, and solutions reached in the Navrongo setting.
- *Demonstrating ways to coordinate CHPS with existing GHS priority programmes*. CHPS is not a vertical programme. It is a strategy for improving the implementation of EPI, school health, family planning, reproductive health, and curative health services. Navrongo counterpart training provides practical experience for coordinating the implementation of CHPS in conjunction with GHS priority programmes.
- *Coordinating M&E activities.* Interacting with counterparts builds practical understanding of the M&E checklist items, ways to orient DHMT in M&E procedures, and strategies for checking on the quality of M&E reports.
- *Learning-by-doing.* Frontline staff, i.e., CHO, serve as on-the-job trainers for counterpart CHO who are assigned to CHC and learn-by-doing. Visiting CHO gain experience on service delivery in Ghana's most deprived and poorest region, which demystifies village posting.
- *Grasping supervisory techniques.* CHPS supervisors are not always clear about what to look for during supervisory missions to the field. In the counterpart approach, trainee supervisors are attached to role-model supervisors who serve as a guide for field activities. District Directors of Health Services and District Nurse Supervisors work with senior CHFP staff. Navrongo counterpart training orients supervisors toward not finding fault and assigning blame, but toward understanding how the system works and how to solve practical problems.
- *Utilizing communities as classrooms*. At every stage of counterpart training the communities serve as classrooms for training health professionals in ways to make the CHFP replicable in other parts of Ghana, and indeed in other parts of the developing world where strategies for organising a community-based health care delivery system that works are still being researched. Once DHMT experience this resource, they can develop pilot communities where CHPS works and where communities may lead other communities in health service innovation

Navrongo demonstrates that districts leading CHPS progress should be providing counterpart support to other districts. Spreading the CHPS message is best achieved by those who know from practical experience what it takes to get started and make the programme work. Where CHPS is working, participants are not talking about the mathematics of steps, milestones, and components. They are simply getting things done.

Send questions or comments to: What works? What fails?
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